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Issue Date: 26 July 2006

Case Nos.: 2005-BLA-5031

In the Matter of:

Ira J. Meade,
Claimant

v.

A & N Coal Company, Inc.,
Employer

and

Director, Office of Workers' Compensation Programs,
Party-In-Interest

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was scheduled and held before the undersigned on March 22, 2006 in Abingdon, Virginia. At the hearing, I admitted Director's Exhibits (DX) 1 to 53, Claimant's Exhibits (CX) 1 to 10, and Employer's Exhibits (EX) 1 to 25.

I have based my analysis on the entire record, including the exhibits and representations of the parties, and have given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

JURISDICTION AND PROCEDURAL HISTORY

The Claimant, Ira J. Meade, filed his claim for benefits on February 12, 2001, which was denied by the District Director on February 12, 2003 (DX 2). On July 23, 2004, the Director issues a Proposed Decision and Order awarding benefits (DX 43). The Employer timely requested a hearing, and on September 29, 2004, the claim was referred to the Office of Administrative Law Judges (DX 51).

ISSUES

The following issues are contested by the Employer.

1. The timeliness of the Claimant's claim.
2. Whether the Claimant has pneumoconiosis.
3. If so, whether the Claimant's pneumoconiosis arose from his coal mine employment
4. Whether the Claimant has a totally disabling respiratory impairment.
5. If so, whether his totally disabling respiratory impairment is due to pneumoconiosis.

(DX 51; Tr. 13-14).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Timeliness of the Claim

The Employer contests the timeliness of the Claimant's claim for benefits. The Claimant's claim was filed on February 12, 2001. 20 C.F.R. § 725.308 provides that

> A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later.

The regulations also provide that there is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. § 725.308(c). The Board has held that a determination of total disability due to pneumoconiosis must be "actually received" by the miner, and if so, there must be a finding that the miner was capable of understanding the report. *Adkins v. Donaldson Mine Co.,* 19 B.R.R 1-34 (1993).

The record in this case does not contain any evidence to suggest that a physician provided the Claimant with a report indicating that he was totally disabled due to pneumoconiosis. Given the presumption that a claim is timely filed, and the total lack of any evidence to rebut this presumption, I find that the Claimant's claim for benefits was timely filed.

Background

The Claimant, Ira J. Meade, was born on October 5, 1954 (DX 2). He completed the ninth grade (DX 2). He married his wife, Joyce Horn, on May 27, 1980; they reside together (DX 2). The Claimant has no children who are under 18 or dependent upon him. I find that the Claimant has one dependent, namely his wife, for purposes of augmentation of benefits.

At the hearing, the Employer agreed that the Claimant worked for 20.74 years in coal mine employment; the Employer does not contest its status as the responsible operator (Tr. 14). This is amply supported by the evidence of record, including the Claimant's Social Security Earnings records, and his pay records (DX 6-10). The Claimant stopped working in the coal mines in November 1999 (DX 2). Accordingly, I find that the Claimant has established 20.74 years of coal mine employment, and that the Employer is properly named as the responsible operator.

Medical Evidence

I have considered the following medical evidence under the limitations of the new regulations.

X-ray Evidence

Exhibit No.	***Date of X-ray***	***Reading Date***	***Physician/ Qualifications***	***Impression***
DX 19	5-16-02	6-28-02	Aycoth/B, BCR	3/2, q, t; Category O opacities
DX 18	5-16-02	10-7-02	Cooper/B	2/1, r, t; Category O opacities
DX 14	3-3-03	3-3-03	Forehand/B	2/2, q, q; Category A opacities
DX 14	3-3-03	3-13-03	Navani/B, BCR	Read for quality purposes
DX 17 EX 1	3-3-03	9-29-03 7-22-05	Hippensteel/B	Negative for pneumoconiosis
CX 5	3-3-03	5-6-05	Aycoth/B, BCR	3/2, q, r; Category O opacities
DX 15/34	3-26-03	4-8-03	Pathak/B, BCR	2/3, q, t; Category O Opacities
DX 17 EX 2	9-16-03	9-16-03 7-22-05	Hippensteel/B	Negative for pneumoconiosis
CX 6	9-16-03	5-6-05	Aycoth/B, BCR	3/2, q, r; Category A opacities

Exhibit No.	*Date of X-ray*	*Reading Date*	*Physician/ Qualifications*	*Impression*
CX 3	11-10-04	11-17-04	Alexander/B, BCR	3/2, q, r; Category A opacities
EX 3	11-10-04	8-25-05	Hippensteel/B	Negative for pneumoconiosis
CX 4	5-5-05	5-16-05	Cappiello/B, BCR	2/3, q, p; Category A opacities
EX 4	5-5-05	8-25-05	Hippensteel/B	Negative for pneumoconiosis

Pulmonary Function Studies

Exhibit No.	*Date*	*Age/Ht*	*FEV1*	*FVC*	*MVV*	*Effort*
DX 14	3-3-03	48/69”	2.73	4.18	101	Good
DX 15/34	3-26-03	48/70”	2.19	3.22		Good
DX 17 EX 5	9-16-03	48/70”	1.93 1.93*	2.60 2.96*	55	
EX 6	11-12-03	49/69”	1.91 2.14*	3.17 3.42*	77	
CX 2	10-4-04	49/70”	1.65	2.78		Good
CX 1	5-5-05	50/68”	1.73	3.11		Good

* Results after administration of bronchodilator

Arterial Blood Gas Studies

Exhibit No.	*Date*	*Physician*	*pCO2*	*pO2*	*At rest/exercise*
DX 14[1]	3-3-03	Forehand	37 30	69 72	At rest After exercise
DX 17 EX 7	9-16-03	Hippensteel	37.9	72.4	At rest

CT Scans

[1] Dr. Michos determined that this test was technically acceptable (DX 14).

The Claimant underwent a chest CT scan on November 21, 2003, which was interpreted by Dr. Basim W. Antoun (CX 7). Dr. Antoun noted extensive bilateral predominantly apical reticulonodular interstitial thickening, with pleural nodularities predominantly in the left posterior hemithorax, and confluence of densities bilaterally centrally and in the right apex. He felt that these findings were compatible with the sequelae of pneumoconiosis, although other etiologies such as tuberculosis could not definitely be ruled out.

Medical Opinion Evidence

Dr. Kirk E. Hippensteel

Dr. Hippensteel examined the Claimant on September 16, 2003 at the Employer's request (DX 17/EX 10). He recorded the Claimant's occupational history, as well as his symptoms and medical history. The Claimant reported that he began smoking about 15 years earlier, up to two packs a day, but currently smoked about one pack every two to three days.

On examination of the Claimant, Dr. Hippensteel noting mild rhonchi bilaterally, with no audible rales. Dr. Hippensteel administered an x-ray, as well as pulmonary function and arterial blood gas testing. The Claimant was not able to perform the exercise test because of back problems. Dr. Hippensteel also reviewed previous x-rays.

According to Dr. Hippensteel, the x-ray films show a rapid development of bilateral nodular infiltrates, some of which are calcified, and which have progressed too rapidly to make pneumoconiosis a likely cause. He referred to a study of coal miners showing that an advancement of one minor category was expected to occur every five years in response to heavy coal dust exposure. But the changes on the Claimant's x-ray have been almost eight times more rapid in development. He felt that although the x-rays did not delineate the exact kind of granulomatous disease present, nevertheless granulomatous disease was the likely cause of the recently developed abnormalities.

Dr. Hippensteel reported that the Claimant had trouble with coughing during forced expiratory efforts on spirometry testing; but his best results still reflected suboptimal peak effort. The Claimant's MVV showed severe reduction with very small suboptimal tidal volumes, which made this part of the testing invalid. The Claimant's lung volume tests showed no restriction, but possibly some air trapping; diffusion was reduced, but only mildly for volume inhaled. The Claimant's arterial blood gas studies at rest showed a normal gas exchange, and a markedly elevated carboxyhemoglobin level, consistent with continued smoking of approximately two packs of cigarettes a day.

After reviewing additional medical records, Dr. Hippensteel concluded that the Claimant had developed significantly abnormal chest x-rays that were most consistent with granulomatous disease, possibly of noninfectious origin, in the last few years. He stated that the rapid development of the abnormalities was inconsistent with pneumoconiosis, which usually progresses in its simple form at the rate of about one subcategory of profusion every five years. He also stated that the presence of calcified lesions was typical for granulomatous disease, rather than pneumoconiosis.

Dr. Hippensteel noted that the Claimant had significant difficulty with the effort dependent parts of the pulmonary testing, but nevertheless had no more than very mild obstructive changes in a study with Dr. Forehand in March. He also had normal gas exchange at rest and with exercise test. According to Dr. Hippensteel, these studies show that the Claimant has the pulmonary capacity to perform his previous coal mining work. The Claimant continues to have symptoms of cough, due to his cigarette smoking, which interfered with the pulmonary function testing.

Dr. Roger J. McSharry

Dr. McSharry examined the Claimant on November 12, 2003 at the Employer's request (DX 17/EX 8). He recorded the Claimant's occupational, social, and medical histories, and his symptoms. On examination of the Claimant, Dr. McSharry noted that his chest was clear to auscultation, without wheezes, rales, or rhonchi; there was no hyperinflation or use of accessory muscles. The Claimant's chest x-ray showed densities compatible with pneumoconiosis 3/2, q, r, which was similar in appearance to granulomatous lung disease. The Claimant's pulmonary function testing showed a severe airflow limitation, with response to bronchodilators. The Claimant's lung capacity was normal, and his diffusion capacity was preserved; there was moderate irreversible airflow obstruction, with some degree of reversible disease, but no restrictive lung disease. The Claimant's arterial blood gas testing was normal, other than an elevated carboxyhemoglobin level that suggested ongoing tobacco use.

Dr. McSharry also reviewed the Claimant's medical records. He concluded that these records showed the presence of bilateral pulmonary nodules in the upper and mid lung zones, with significantly fewer in the lower lung zones. There were areas of confluence in four regions through the right lung, and three regions in the left lung. The lesions were size q/r, and profusion 3/2 in the upper and mid lung zones bilaterally. He felt that a few of the lesions could be calcified, but the majority were not; he saw no clear cut hilar or mediastinal calcification. His impression was that these were changes compatible with pneumoconiosis, although the pattern could also be due to infectious granulomatous disease.

Dr. McSharry agreed that the Claimant's x-ray was abnormal, and compatible with a diagnosis of pneumoconiosis, although granulomatous lung disease could also account for these changes. According to Dr. McSharry, the rapid progression of the x-ray changes over the preceding three to five years was extremely unusual for pneumoconiosis, and convincingly argued that the abnormalities were not caused by coal mining or coal dust exposure. He felt that it would be very unusual for such x-ray findings to be caused by coal dust exposure.

Dr. McSharry felt that the pulmonary function test results were moderately abnormal, and were to some degree reversible, which is not typical of pneumoconiosis. The irreversible portion of the abnormalities was purely obstructive; according to Dr. McSharry, pure obstructive lung disease caused by pneumoconiosis is uncommon, and typically one would expect it to be accompanied by significant abnormalities of restrictive lung disease and diffusion abnormalities. He felt that the Claimant's prolonged history of smoking was a much more likely explanation.

Dr. McSharry concluded that there was insufficient objective evidence to support a diagnosis of pneumoconiosis. He felt that the Claimant's respiratory impairment was sufficient to impair him from performing his recent coal mining job, but this disability could not reasonably be attributed to his exposure to coal dust.

Dr. Steven M. Koenig

Dr. Koenig reviewed the Claimant's medical records at the Employer's request, and prepared a report dated November 12, 2003 (DX 17/EX 9). He concluded that the Claimant's exposure to coal dust was sufficient to cause respiratory impairment in a susceptible individual. The records showed evidence of obstructive lung disease, with very mildly decreased pre-bronchodilator pulmonary function study results. There was no evidence of restrictive lung disease, and the arterial blood gas studies were normal.

Dr. Koenig felt that although the Claimant had an abnormal chest x-ray, consistent with pneumoconiosis, there was no pulmonary function test evidence that it was causing impairment. He stated that when simple pneumoconiosis causes impairment, it typically does so by causing restrictive pulmonary function results. The Claimant had evidence of obstructive lung disease; potential explanations include asthma and chronic obstructive pulmonary disease, and possible causes include his significant smoking history and his coal dust exposure.

But Dr. Koenig stated that at the most, the Claimant has very mild obstructive lung disease. He felt that the administration of bronchodilators, had that been done, could have brought his results into the normal range. But even if the Claimant had very mild COPD from coal dust exposure, there was no evidence that it was so severe to prevent him from performing his last job in the mines.

Dr. J. Randolph Forehand

Dr. Forehand examined the Claimant on March 3, 2003 at the request of the Department of Labor (DX 14). Dr. Forehand recorded the Claimant's occupational history, as well as his medical and social histories, and symptoms. He reported that the Claimant started smoking in 1972, and currently smoked about a half pack of cigarettes a day. On examination of the Claimant, Dr. Forehand noted abnormal breath sounds on auscultation, with crackles at the bases. The Claimant's x-ray showed pneumoconiosis; pulmonary function testing showed mild airflow limitation. The Claimant's arterial blood gas tests showed no arterial hypoxemia or metabolic disturbance.

Based on the Claimant's history, physical examination, and x-ray results, Dr. Forehand determined that he had pneumoconiosis, due to his exposure to coal dust. He stated that the Claimant has a significant respiratory impairment, and is not able to return to work; he is totally and permanently disabled. According to Dr. Forehand, pneumoconiosis is the sole factor contributing to his respiratory impairment.

The Claimant was treated by Dr. Forehand at The Clinch Valley Physicians Clinic, and the record includes treatment notes from January 2004 to March 2005 (CX 8). In his March 7,

2005 note, Dr. Forehand noted the Claimant's history of complicated pneumoconiosis and shortness of breath with nasal congestion. On examination of the Claimant, Dr. Forehand noted breath sounds over all lung fields, although they were diffusely diminished; there were inspiratory crackles at the bases, and no wheezes. Dr. Forehand administered pulmonary function and arterial blood gas testing. His impression was progressively worsening complicated pneumoconiosis, with borderline arterial hypoxemia.

Dr. Forehand saw the Claimant on September 2, 2004 for complaints of progressively worsening shortness of breath. Dr. Forehand noted his employment history, and indicated that the Claimant smoked up to a half pack of cigarettes a day. He referred to a November 21, 2003 CT scan that showed typical findings of complicated pneumoconiosis, including large fibrotic masses extending to the pleural lining of the upper lobes bilaterally. He indicated that other possible causes for the Claimant's abnormal chest x-ray and CT scan, such as cancer, tuberculosis, or other granulomatous or infectious diseases had been ruled out in the past with specific laboratory tests, and by following the appearance of the Claimant's x-ray and tracking his symptoms. According to Dr. Forehand, the Claimant continued to show no evidence of cancer or tuberculosis, so he was able to say with the highest degree of medical certainty that the Claimant had complicated pneumoconiosis, and not cancer, tuberculosis, or other granulomatous or infectious disease. Dr. Forehand stated that the Claimant continued to show no evidence of weight loss, loss of appetite, unexplained fever, chills, night sweats, rash, blurred vision, spitting up blood or nausea or vomiting, diarrhea, or jaundice.

On his examination of the Claimant, Dr. Forehand noted breath sounds over all lung fields, with inspiratory crackles at the bases, and no wheezes. His impression was worsening complicated pneumoconiosis; disabling shortness of breath; and a totally and permanently disabling respiratory impairment that would prevent the Claimant from returning to his previous coal mining job.

Dr. Forehand saw the Claimant on April 1, 2004, for problems related to coal workers' pneumoconiosis. On examination of the Claimant, Dr. Forehand noted bilaterally diminished breath sounds with occasional expiratory wheezing. Spirometry testing showed airflow limitation, with the FEV1 at 56% of predicted. Dr. Forehand's impression was complicated pneumoconiosis by history, and airflow limitation stemming from occupational pneumoconiosis.

The Claimant saw Dr. Forehand on February 17, 2004 for problems related to coal workers' pneumoconiosis. Dr. Forehand indicated that the Claimant was a disabled coal miner with complicated pneumoconiosis and recently diagnosed sinusitis. On examination of the Claimant, Dr. Forehand noted diminished breath sounds, with expiratory wheezes at the bases. His impression was complicated pneumoconiosis, air flow limitation stemming from occupational pneumoconiosis, and resolving sinusitis.

The Claimant first saw Dr. Forehand on January 6, 2004 for his respiratory problems. The Complainant had shortness of breath and chest discomfort, particularly with activity or exertion. The Nurse Practitioner, Jennifer Elswick, noted the Claimant's work and social history, as well as his medical history. On examination, the Claimant had breath sounds with scattered wheezing throughout, with no change or improvement after coughing. Spirometry

testing showed airflow limitation, with an FEV1 of 58% of predicted. The report indicated that the Claimant also had pulmonary function testing in March 2003 with Dr. Forehand, at which time the FEV1 was 77% of predicted. The Claimant's November 21, 2003 chest CT scan showed coal workers' pneumoconiosis.

Ms. Elswick included in her impression questionable respiratory allergies, rhinosinusitis, coal workers' pneumoconiosis by history diagnosed in 2003 by Dr. Forehand, and chronic obstructive pulmonary disease with mild exacerbation.

Dr. Michael H. Clary

The record includes a letter and office notes from Dr. Clary, who is the Claimant's treating physician (CX 9, 10). Dr. Clary wrote a letter dated April 15, 2004 indicating that the Claimant had been his patient since February 2001. He stated that the Claimant had a history of intermittent chronic lung problems, and a long history of working in the coal mines. According to Dr. Clary, the Claimant had a long standing history of lung problems due to black lung, and he recently had spirometry testing with decreased flow rates in multiple areas, and an average lung age of 113 years. Dr. Clary stated that the Claimant has black lung, which has made it difficult for him to sustain gainful employment.

Dr. Clary saw the Claimant on August 6, 2004, at which time the Claimant told him that he had tried to quit smoking, but was still smoking a pack of day. On examination of the Claimant, Dr. Clary noted decreased breath sounds, but clear lungs. His assessment was rule out jaundice; COPD, CWP stage 2-3; chronic low back pain and lumbar disc disease; GERD; erectile dysfunction; tobacco abuse; and rule out hyperlipidemia.

The Claimant visited Dr. Clary on June 14, 2004 for refills of pain medication. Dr. Clary noted that his lungs were clear to auscultation, with decreased breath sounds. His assessment was COPD/CWP, stage II to III; chronic low back pain; GERD; erectile dysfunction; and tobacco abuse.

Dr. Clary saw the Claimant on April 15, 2004, noting that he had decreased breath sounds. His assessment was COPD/CWP, stage 2-3/bronchitis; chronic low back pain; GERD; erectile dysfunction; and tobacco abuse.

The Claimant visited Dr. Clary on February 20, 2004; October 14, 2003; August 14, 2003; and December 18, 2003. Dr. Clary noted decreased breath sounds on each visit. His assessment continued to be COPD/CWP, stage 2-3; chronic low back pain; GERD; erectile dysfunction; and tobacco abuse. On his February 20, 2004 note, Dr. Clary indicated that spirometry testing had been done, and the Claimant had a lung age of 113 years, with obstructive and restrictive components.

The record also includes a report of a history and physical examination on February 2, 2001 (EX 11). The Claimant visited Dr. Clary with complaints of back pain and knots on his stomach. After examination of the Claimant, Dr. Clary diagnosed chronic low back pain/lumbar disc disease, status post surgery, abdominal wall masses, and tobacco abuse. The Claimant

followed up on June 19, 2001, at which time Dr. Clary noted that he had clear but diminished breath sounds. Dr. Clary again diagnosed him with chronic lumbar pain. The Claimant's treatment notes reflect that Dr. Clary continued to see the Claimant through November 14, 2002 for treatment of his chronic lower back pain and tobacco abuse (EX 14-23). At the Claimant's November 14, 2002 visit, he reported intermittent shortness of breath. Dr. Clary noted occasional slight crackles, but no rhonchi, rales, or wheezing. Along with chronic lower back pain, he diagnosed COPD/CWP/tobacco abuse.

On his June 2, 2003 visit to the clinic, the Complainant saw Dr. Patel, who reported that the Claimant had pain in his lumbar area; his assessment was lumbar disc disease with myelopathy, and gastroesophageal reflux disease. Despite unremarkable findings on his review of systems, Dr. Patel included COPD in his assessment.

Dr. Amjad Husain

The record includes an office note from Dr. Hussain dated July 24, 2003 (EX 25). It indicates that the Claimant brought an x-ray report, which was read as showing minute soft rounded parenchymal density scattered throughout both lungs, with hyperinflated lungs. Dr. Husain felt that although no conglomerate pneumoconiosis was noted, the x-ray was consistent with pneumoconiosis. Dr. Husain reported that the Claimant underwent a pulmonary function study on March 26, 2003, which showed a moderately decreased FEV1, and mild obstructive ventilatory impairment. His FEF 25/75 was severely decreased. He felt that this study was consistent with moderate obstructive ventilatory impairment; response to bronchodilators was not known. Dr. Husain strongly urged the Claimant to quit smoking. His assessment was coal workers' pneumoconiosis, and chronic obstructive pulmonary disease.

DISCUSSION

Existence of Pneumoconiosis

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The regulations at 20 C.F.R. § 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the claimant must establish causation by competent evidence. *Stark v. Director, OWCP,*9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.,*9 B.L.R. 1-137 (1986). The claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See, Director, OWCP v. Greenwich Collieries,* 114 S.Ct. 2251 (1995).

Because the current claim was filed after the enactment of the Part 718 regulations, the evidence will be evaluated under standards found in 20 C.F.R. Part 718. The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-

rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a). I have independently assessed the evidence under each of these methods.

To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis. The record in this case includes twelve interpretations of six x-rays, performed between 2002 and 2005. The first x-ray, which was performed on May 16, 2002, was interpreted as positive by Dr. Cooper, who is a B reader, and Dr. Aycoth, who is dually qualified.

The next x-ray was performed on March 3, 2003. Dr. Forehand, who is a B reader, and Dr. Aycoth, who is dually qualified, read it as positive for pneumoconiosis, while Dr. Hippensteel, who is a B reader, read it as negative. Given the positive interpretation by Dr. Aycoth, the dually qualified reader, I find that this x-ray is positive for pneumoconiosis.

The next x-ray, which was performed on March 26, 2003, was read by Dr. Pathak, who is dually qualified, as positive; there are no contrary interpretations.

The x-ray that was performed on September 16, 2003, was interpreted by Dr. Hippensteel, a B reader, as negative, but by Dr. Aycoth, who is dually qualified, as positive. Given Dr. Aycoth's superior qualifications, I find that this x-ray is positive for pneumoconiosis.

An x-ray performed on November 10, 2004 was interpreted by Dr. Alexander, who is dually qualified, as positive, and an x-ray performed on May 5, 2002, was interpreted by Dr. Cappiello, who is dually qualified, as positive. Dr. Hippensteel also reviewed these x-rays, and found them to be negative. However, relying on the superior qualifications of Dr. Alexander and Dr. Cappiello, I find that these x-rays are positive for pneumoconiosis.

As I have determined that all of the x-rays are positive, I find that the Claimant has established the existence of pneumoconiosis by a preponderance of the x-ray evidence.

There is no autopsy or biopsy evidence in the record. The Claimant underwent a CT scan on November 21, 2003. Dr. Antoun reported that it showed extensive bilateral predominantly apical reticulonodular interstitial thickening, pleural nodularities predominantly in the left posterior hemithorax, and a confluence of densities bilaterally centrally and in the right apex. He felt that these findings were compatible with pneumoconiosis, although he could not definitely rule out other etiologies such as tuberculosis.

Dr. Forehand, the Claimant's treating physician, also reviewed this CT scan, noting that it showed findings typical of complicated pneumoconiosis, including large fibrotic masses that extended to the pleural lining of the upper lobes bilaterally. He reported that other possible causes for these abnormalities, such as cancer, tuberculosis, or other granulomatous or infectious diseases had been ruled out with specific laboratory tests, and by tracking the Claimant's x-ray and symptoms.

With respect to the medical opinion reports, Dr. Forehand, who is the Claimant's treating physician, has concluded that he has pneumoconiosis as a result of his exposure to coal mine dust. Dr. Forehand based his conclusion on his examinations of the Claimant, the results of objective testing, and his observations of the Claimant over a period of time. He also explained why other etiologies for the Claimant's x-ray abnormalities and pulmonary difficulties, such as cancer, tuberculosis, or infectious disease, could be ruled out. I find that Dr. Forehand's opinions are well-reasoned and thoroughly documented, and I accord them significant weight.

Dr. Clary, who has treated the Claimant in connection with his breathing and back problems, consistently diagnosed him with COPD and coal workers' pneumoconiosis. However, he did not provide the basis for his assessment of pneumoconiosis, or refer to any objective testing, and I find that his opinions are not entitled to significant weight. Similarly, Dr. Husain saw the Claimant on July 24, 2003, and reviewed the results of an x-ray, which he stated was read as showing minute soft rounded parenchymal density scattered throughout both lungs, consistent with pneumoconiosis. However, Dr. Husain did not indicate the date of this x-ray, or the name of the physician who interpreted it. I find that Dr. Husain's report of the x-ray results obtained by an unknown physician on an unknown date is not entitled to any weight.

Although he acknowledged that the Claimant's x-ray was compatible with pneumoconiosis, Dr. McSharry felt that it also was similar in appearance to granulomatous disease. On his review of the Claimant's records, however, he reported that there were few calcifications on x-ray. He also felt that the rapid progression of the Claimant's x-ray abnormalities was atypical for pneumoconiosis, as was the partial reversibility on pulmonary function testing. He felt that there was insufficient objective evidence to support a finding of pneumoconiosis. However, I find Dr. McSharry's discussion to be incomplete, as he did not consider Dr. Forehand's report that other etiologies for the x-ray abnormalities could be ruled out. The Claimant's CT scan was performed after Dr. McSharry's examination; if Dr. McSharry reviewed it, there is no evidence of this in the record.

Dr. Hippensteel acknowledged that there were abnormalities on the Claimant's x-rays, but he felt that they were due to granulomatous disease. He also felt that the development of the nodular infiltrates was too rapid for pneumoconiosis. Dr. Hippensteel based his opinions in part on the calcifications on x-ray, which Dr. McSharry described as few in amount. Nor did Dr. Hippensteel address Dr. Forehand's exclusion of other etiologies, such as granulomatous or infectious disease, for the abnormalities on x-rays. Although Dr. Hippensteel reviewed the Claimant's x-rays, for the second time, as late as August 2005, there is nothing to reflect that he was provided with the Claimant's November 21, 2003 CT scan.

I find that Dr. McSharry's and Dr. Hippensteel's reports are incomplete and inconclusive, and not based on the totality of the available medical evidence. Their claim that the abnormalities they acknowledge on the Claimant's x-rays can be attributed to granulomatous or infectious disease has been effectively discredited by Dr. Forehand, who has explained in detail why those etiologies can be ruled out. Even if they had provided any support for their statements that the rapid development of the x-ray abnormalities was atypical for pneumoconiosis, they have not explained why that conclusively rules out pneumoconiosis as a cause for the

abnormalities, albeit "atypical." Nor did either physician review or discuss the Claimant's CT scan, or address the findings by Dr. Antoun and Dr. Forehand.

I rely on the opinions of Dr. Forehand, whose reports I find to be well-reasoned and documented by the objective medical evidence of record. As the Claimant's treating physician, he has had the opportunity to examine and observe him over a period of time. He has also relied on objective testing, and explained in detail the basis for his conclusions. Accordingly, I find that the Claimant has established the existence of pneumoconiosis by the medical opinion evidence.

Finally, weighing all of the evidence regarding the existence of pneumoconiosis together, I find that the Claimant has established the existence of pneumoconiosis by a preponderance of the persuasive medical evidence.

Total Disability Due to Pneumoconiosis

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right-sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment. 20 C.F.R. §718.204(b)(2).

In this case, the results of the pulmonary function and arterial blood gas tests do not establish presumptive disability under the regulations. Nor is there any evidence in the record to establish that the Claimant has cor pulmonale with right-sided congestive heart failure. However, based on the opinion of Dr. Forehand, I find that the Claimant has established that he is totally disabled from returning to his previous coal mining employment, due to his pneumoconiosis.

Dr. Forehand examined the Claimant at the request of the Director, and subsequently began treating him. Based on his clinical findings during the March 3, 2003 examination, as well as the results of the pulmonary function tests, which showed mild airflow limitation, Dr. Forehand concluded that the Claimant had a significant respiratory impairment, and was not able to return to his previous work. He felt that the Claimant's pneumoconiosis was the sole factor in his respiratory impairment.

Dr. Forehand's subsequent treatment notes document the Claimant's progressively worsening shortness of breath, and his development of borderline arterial hypoxemia, as well as increased airflow limitation.

Neither Dr. Clary nor Dr. Patel, who also treated the Claimant, offered any opinions as to the extent of the Claimant's respiratory disability. Although Dr. Husain discussed the results of the Claimant's March 26, 2003 pulmonary function studies, which he felt were consistent with moderate obstructive ventilatory impairment, he did not offer any opinion about the degree of the Claimant's respiratory impairment.

Dr. McSharry, who examined the Claimant and reviewed medical records, concluded that he was disabled from a pulmonary standpoint from performing his previous coal mining work. But he felt that it was not reasonable to attribute this disability to the Claimant's exposure to coal dust. He pointed to the fact that the results of the Claimant's pulmonary function testing were reversible to some degree, which is not typical of pneumoconiosis. He noted that the irreversible portion was purely obstructive, which, according to Dr. McSharry, was uncommon with pneumoconiosis, and would be expected to be accompanied by significant restrictive and diffusion abnormalities. But the Courts have clearly recognized that pneumoconiosis can result in purely obstructive impairment. I find that Dr. McSharry's choice of the Claimant's history of smoking as the "much more likely" explanation for his respiratory impairment, and the total exclusion of the Claimant's pneumoconiosis as a factor in that impairment, was too heavily influenced by his expectation that respiratory disability caused by pneumoconiosis should include restrictive lung disease and diffusion abnormalities. In combination with his designation of smoking as the "much more likely" cause of impairment, I find that Dr. McSharry's opinion is not well reasoned or supported, as well as equivocal, and I accord it little weight.

Dr. Koenig reviewed the Claimant's medical records, and concluded that although he had x-ray abnormalities consistent with pneumoconiosis, there was no pulmonary function test evidence to show that it was causing the Claimant impairment. He concluded that the Claimant has very mild obstructive disease, which is not so severe to prevent him from performing his last job in the mines. However, Dr. Koenig's conclusions are based on an incomplete review of the record, as there were two pulmonary function studies performed after his examination of the Claimant. Although he indicated that when simple pneumoconiosis causes impairment, it typically does so by causing restriction, he also stated that possible causes of the Claimant's obstructive lung disease included both his smoking history and his exposure to coal dust. I find that Dr. Koenig's opinions are simply too equivocal and based on an incomplete review of the medical evidence, and I accord them little weight.

Dr. Hippensteel, who also examined the Claimant and reviewed selected medical records, was not able to obtain reliable pulmonary function study results, but he noted that the results obtained by Dr. Forehand a few months earlier showed no more than very mild obstructive changes, and no gas exchange abnormalities. He felt that these studies showed that the Claimant had the pulmonary capacity to continue his previous coal mining work. However, there is no indication that Dr. Hippensteel reviewed the results of the three pulmonary function studies performed after he examined the Claimant. I find that Dr. Hippensteel's opinions are based on an incomplete review of the medical evidence, and I accord them little weight.

Thus, relying on the opinions of Dr. Forehand, who as the Claimant's treating physician, has had the opportunity to assess his condition over time, and who provided a detailed and

supported explanation of the basis for his opinions, I find that the Claimant has established that he is totally disabled due to pneumoconiosis.

In addition, Section 718.304 provides for an irrebuttable presumption of total disability due to complicated pneumoconiosis if a claimant suffers from a chronic dust disease of the lung which (a) when diagnosed by x-ray yields one or more large opacities greater than one centimeter in diameter, and would be classified as Category A, B, or C; (b) when diagnosed by biopsy or autopsy yields massive lesions in the lung; or (c) when diagnosed by means other than those specified in (a) or (b) would be a condition which could reasonably be expected to yield the results described in (a) or (b).[2] In determining the validity of claims, all relevant evidence must be considered. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-09 (4th Cir. 2000). However, once the Claimant has provided evidence satisfying one of these prongs, if the Employer can affirmatively show that the opacity is not there or is something other than pneumoconiosis, the x-ray loses force, and the Claimant is not entitled to the benefits of the presumption. *See Scarbro*, 220 F.3d at 256.

In *Scarbro,* the ALJ determined that x-ray and autopsy evidence were sufficient to invoke the presumption under 20 C.F.R. § 718.304(c). The Court discussed the three different ways set forth in the statute to establish the existence of statutory complicated pneumoconiosis in order to invoke the irrebuttable presumption, and noted that

> While 30 U.S.C. §921(c)(3) sets forth, in clauses (A), (B), and (C), three different ways to establish the existence of statutory complicated pneumoconiosis for purposes of invoking the irrebuttable presumption, these clauses are intended to describe a single, objective condition. . . And, because prong (A) sets out an entirely objective scientific standard—i.e. an opacity on an x-ray greater than one centimeter—x-ray evidence provides the benchmark for determining what under prong (B) is a massive lesion and what under prong (C) is an equivalent diagnostic result reached by other means.
>
> Prongs (A), (B), and (C) are stated in the disjunctive; therefore a finding of statutory complicated pneumoconiosis may be based on evidence presented under a single prong. But the ALJ must in every case review the evidence under each prong of §921(c)(3) for which relevant evidence is presented to determine whether complicated pneumoconiosis is present. Evidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict. Yet, a single piece of relevant evidence can support an ALJ's finding that the irrebuttable presumption was successfully invoked if that piece of evidence outweighs conflicting evidence in the record. **Thus, even where some x-ray evidence indicates opacities that would**

[2] If the Claimant establishes the existence of complicated pneumoconiosis, then he has successfully established total disability due to pneumoconiosis.

> **satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) or (C), then all of the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray. Of course, if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problems with the equipment used, or incompetence of the reader.**

Scarbro, 220 F.3d at 255-6 (internal quotations and citations omitted, emphasis added). The Fourth Circuit discussed the statutory definition of "complicated pneumoconiosis," noting that it is not congruent with a medical or pathological condition. The Court noted that the statute creating the irrebuttable presumption of causation does not refer to the condition as "complicated pneumoconiosis," or to a medical condition that doctors have independently called complicated pneumoconiosis. As the Court stated

> [T]he presumption under § 921(c)(3) is triggered by a congressionally defined condition, for which the statute gives no name but which, if found to be present, creates an irrebuttable presumption that disability or death was caused by pneumoconiosis. . . . In short, the statute betrays no intent to incorporate a purely medical definition.

Id. at 257.

I view the Court's decision in *Scarbro* to require that, when the Claimant presents evidence satisfying § 718.304 and the Employer also presents relevant x-ray evidence or evidence relevant to prongs (B) or (C), I must determine if the evidence under these prongs as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter. This evidence loses force *only if* evidence is presented that affirmatively shows either that the opacities are not there, or that they are not what they seem to be. If the evidence fails to meet this burden, the Claimant is entitled to the benefit of the § 718.304 presumption.[3]

1. Existence of an Opacity Greater than 1 Centimeter

[3] The standard that requires the Employer to "affirmatively show" that the opacities are not there or are not what they seem to be—i.e., that the opacities are not pneumoconiotic category A opacities—is a burden imposed by the Court in *Scarbro.*

The record in this case includes twelve interpretations of six different x-rays performed between 2002 and 2005. Of these, four interpretations of the films include findings of Category A opacities. Thus, in this case, there is x-ray evidence that satisfies the requirements of prong (A), in the form of the four interpretations with findings of Category A opacities caused by coal dust exposure. However, there is also other x-ray evidence available, as well as other evidence relevant to an analysis under prong (C). Thus, "even where some x-ray evidence indicates opacities that would satisfy (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) or (C), then all of the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." [4] *Scarbro*, 220 F.3d at 256 (emphasis added).

In addition to the x-ray interpretations, the record includes two interpretations of the Claimant's November 21, 2003 chest CT scan, evidence that falls under prong (C). Dr. Antoun, who reviewed this CT scan, described extensive bilateral reticulonodular interstitial thickening, with pleural nodularities and bilateral confluence of densities, compatible with pneumoconiosis. While Dr. Antoun did not describe the dimensions of the densities, and thus, his CT scan review, standing alone, would not be sufficient to support a finding of complicated pneumoconiosis under the *Scarbro* analysis, nevertheless, it lends credence and support to the designation of Category A opacities by the dually qualified readers.

Dr. Forehand also discussed this CT scan, indicating that it showed typical findings for complicated pneumoconiosis, including large fibrotic masses extending to the pleural lining of the upper lobes bilaterally. Again, Dr. Forehand did not indicate the dimensions of these masses, but his report is clearly consistent with a finding of Category A opacities.

I find that the preponderance of the evidence clearly shows that the Claimant has established that he has a condition that shows up on x-ray as a one centimeter or greater opacity in his lungs. I find that the Claimant has established the presence of an opacity measuring at least one centimeter in diameter as required by the plain language of 30 U.S.C. § 921(c)(3)(A).

2. Etiology of the Opacity/ Mass

In addition to establishing the existence of a one centimeter or greater opacity, § 718.304 requires that the etiology of these opacities be coal-dust related. Under *Scarbro*, once the Claimant establishes this etiology, the Employer must provide evidence that affirmatively shows the opacities are not there or that they are from a disease process other than complicated pneumoconiosis. Here, Dr. Forehand, Dr. Aycoth, Dr. Alexander, and Dr. Cappiello concluded that the Claimant has pneumoconiosis, and that the large opacities are due to pneumoconiosis.

I note that in his report, dated September 16, 2003, Dr. Hippensteel indicated that the Claimant's March 3, 2003 and September 16, 2003 x-rays showed extensive infiltrates with first a 3/2, then a 3/3 profusion, which had coalesced. However, he did not describe the dimensions of these areas of coalescence. In his review of the Claimant's November 10, 2004 x-ray, Dr. Hippensteel again noted bilateral diffuse nodular infiltrates, and on the March 5, 2005 x-ray, he

[4] There is no evidence in the record that falls under prong (B).

noted diffuse upper lobe nodules with some coalescence in both apices. But again, he did not describe the dimensions of the areas of coalescence. Dr. Hippensteel found the Claimant's x-rays negative for pneumoconiosis. However, this is contrary to my finding that the x-rays establish the existence of pneumoconiosis.

With the exception of Dr. Hippensteel, all of the physicians who read the Claimant's x-rays concluded that they showed pneumoconiosis. I find Dr. Aycoth's interpretations especially persuasive, as they show a progression from May 16, 2002 and March 3, 2003, when he noted a profusion of 3/2 and Category O opacities, to September 16, 2003, when he noted a profusion of 3/2, with Category A opacities. Although Dr. Pathak, who reviewed the March 26, 2003 x-ray, noted a 2/3 profusion, and Category O opacities, the subsequent x-rays were interpreted to show Category A opacities by Dr. Aycoth (September 16, 2003), Dr. Alexander (November 10, 2004), and Dr. Cappiello (May 5, 2005).

The only physician to read the x-rays and conclude that the abnormalities shown on the films are not due to pneumoconiosis was Dr. Hippensteel. But I find that his conclusions are outweighed by the findings of those physicians, both B readers and dually qualified physicians, who have concluded that these abnormalities are due to pneumoconiosis. In addition, as discussed above, Dr. Forehand, the Claimant's treating physician, has ruled out other possible etiologies, including granulomatous disease, as the cause of the Claimant's x-ray abnormalities. I find Dr. Hippensteel's opinions to be speculative, and based on an incomplete review of medical evidence, and I accord them little, if any weight.

I have evaluated the x-ray evidence, in conjunction with the CT scan evidence, and find that the Claimant has satisfied his burden of proving that he suffers from the statutorily defined condition referred to as complicated pneumoconiosis. Thus, the Claimant has established that he has a condition that shows up on x-ray as a Category A opacity. The Employer has failed to provide persuasive x-ray or CT scan evidence affirmatively showing that the opacities are not there, or that they are due to a process other than pneumoconiosis.

Weighing All Evidence Together

Upon reviewing all of the evidence together, I find that the Claimant has established that he is entitled to the presumption of total disability due to complicated pneumoconiosis. I find that the preponderance of the persuasive x-ray evidence establishes that the Claimant has a condition that has resulted in the presence of large opacities on x-ray, due to his more than twenty years of occupational exposure to coal dust.

But the Employer has not offered persuasive affirmative evidence that the large opacities are due to something other than exposure to coal dust. The record contains no evidence of exposure to causative agents other than coal dust, such as asbestos or tuberculosis. Nor are there any treatment records indicating that the Claimant has ever been diagnosed with or treated for tuberculosis, granulomatous, or any other pulmonary impairment that would produce opacities on an x-ray. Indeed, Dr. Forehand, the Claimant's treating physician, specifically reported that other possible causes for the abnormalities on x-ray and CT scan had been ruled out with specific laboratory tests, and by following the appearance of the Claimant's x-ray and symptoms. Dr.

Forehand reported that the Claimant showed no evidence of cancer or tuberculosis, and none of the symptoms associated with infectious or granulomatous disease.

Dr. Hippensteel, who acknowledged a profusion of abnormalities as well as coalescence on the Claimant's x-rays, stated that these abnormalities were "consistent with" granulomatous disease. I find that Dr. Hippensteel's conclusions are speculative, and not affirmative evidence that the abnormalities he identified are due to a process other than pneumoconiosis. But in addition, I find that Dr. Hippensteel's opinions are based on incomplete information. Thus, although he was asked to review x-rays as late as 2005, either he was not provided with the November 2003 CT scan, or he was provided with this film but his review was not submitted into the record. Neither alternative reflects well on his credibility.

Thus, I find that the preponderance of the evidence points to coal dust exposure as the etiology for the Claimant's radiographic abnormalities.

The Fourth Circuit has stated that "because prong (A) sets out an entirely objective scientific standard" –i.e. an opacity on an x-ray greater than one centimeter –x-ray evidence provides the benchmark for determining what under prong (B) is a "massive lesion" and what under prong (C) is an equivalent diagnostic result reached by other means. Thus, the "other means" are medical tests, such as CT scans, that will provide a diagnostic result that is equivalent to the objective finding of an opacity on x-ray greater than one centimeter. But it is not a catch-all provision that allows for consideration of all other evidence in the record.

Thus, Dr. McSharry examined the Claimant and reviewed his medical records. However, his interpretation of the Claimant's x-ray is not in the record, as the Employer did not designate it under the evidentiary guidelines of the new regulations. As his report does not fall under prong (A), (B), or (C), it is not properly considered in determining whether the Claimant has established his entitlement to the statutory presumption. Nevertheless, in weighing all of the evidence, I have considered Dr. McSharry's report.

Dr. McSharry reviewed x-ray reports by other physicians, noting that those from 2002 and 203 showed marked abnormalities of advanced degree, using ILO criteria. As he did not specifically indicate which x-rays he reviewed, it is not possible to ascertain whether he reviewed the x-ray report by Dr. Forehand, with his designation of Category A opacities. In any event, although he concluded that there were areas of confluence in four regions through the right lung, and three regions in the left lung, Dr. McSharry did not indicate the dimensions of these "areas of confluence," or otherwise address the question of whether there was x-ray evidence that would meet the statutory requirements to establish complicated pneumoconiosis. Nor did Dr. McSharry address the findings by Dr. Antoun and Dr. Forehand on the Claimant's November 2003 CT scan. I find that Dr. McSharry's opinions are based on an incomplete review of the medical evidence, but nevertheless are not contrary to a conclusion that the Claimant has abnormalities that appear as Category A opacities on x-ray, and that these abnormalities are due to pneumoconiosis.

Similarly, Dr. Koenig read the Claimant's May 16, 2002 x-ray, but as the Employer did not designate it under its evidentiary limitations, this interpretation is not part of the record. Dr.

Koenig also reviewed the x-ray reports by Dr. Cooper and Dr. Aycoth (May 16, 2002), and Dr. Pathak (March 26, 2003). Although he referred to Dr. Forehand's medical report, and the results of his pulmonary function and arterial blood gas studies, Dr. Koenig apparently was not provided with Dr. Forehand's x-ray report, with its findings of Category A opacities. Nor did Dr. Koenig have available the subsequent interpretations by Dr. Aycoth, Dr. Alexander, or Dr. Cappiello, with their findings of Category A opacities, or the reports on the Claimant's November 2003 CT scan. Dr. Koenig concluded that there was x-ray evidence of simple pneumoconiosis; not surprisingly, he did not address the question of whether the Claimant had evidence of the statutory condition known as complicated pneumoconiosis. I find that Dr. Koenig's report is demonstrably incomplete, and of no assistance in assessing whether the Claimant has met the requirements of Section 718.304, other than to confirm that the abnormalities he noted in the very limited number of x-ray reports he reviewed were due to pneumoconiosis.

I find that there is no consistent, corroborated, or affirmative evidence that the large opacities identified by I find that the Claimant has established that he is totally disabled due to pneumoconiosis, by virtue of his arterial blood gas test results and the opinions of Dr. Rasmussen, and alternatively that he is entitled to the statutory presumption of total disability due to pneumoconiosis afforded by Section 718.304. Therefore, he is entitled to benefits under the Act.

The fact remains, there is no consistent, corroborated, or affirmative evidence that the large opacities identified by Dr. Forehand, Dr. Alexander, Dr. Aycoth, and Dr. Cappiello are not there, or are due to an intervening pathology. I find that their opinions are not affirmative evidence under *Eastern Associated Coal*. .

The Fourth Circuit's language in *Scarbro* is straightforward. The Court has made it clear that under the statute, a claimant who meets the congressionally defined condition is entitled to the irrebuttable presumption that he is totally disabled due to pneumoconiosis. The Claimant is not required to establish that he has the medical condition known as complicated pneumoconiosis. Rather, once the Claimant shows, by a preponderance of the x-ray, autopsy or biopsy, or equivalent objective medical evidence that he has a condition that shows up on x-ray as a large opacity due to coal dust exposure, he is entitled to benefits unless the Employer affirmatively shows, by persuasive objective medical evidence, either that the opacities are not there, or that they are due to a process other than pneumoconiosis. I find that the Claimant has met these requirements, and that the Employer has not met the burden imposed on it by the Court in *Scarbro* to affirmatively establish that the opacities are due to a process other than pneumoconiosis. Thus, the Claimant has established that he has pneumoconiosis that arose out of his coal mine employment, and that he is totally disabled due to his pneumoconiosis. The Claimant is therefore entitled to benefits under the Act.

CONCLUSION

I find that the Claimant has established that he has pneumoconiosis, and that he is totally disabled due to pneumoconiosis. He is therefore entitled to benefits under the Act.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED that the claim of Ira J. Meade for benefits under the Act is GRANTED.

IT IS FURTHER ORDERED that the Employer, A & N Coal Company, shall pay to the Claimant all benefits to which he is entitled under the Act commencing in February 2001. [5]

SO ORDERED.

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LINDA S. CHAPMAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

[5] As I have found that the Claimant established entitlement by virtue of the medical opinion reports as well as the irrebuttable presumption, I have used his date of application as the date of onset of benefits.